

There are many countries, irrespective of the international rules, that participate in these informal drugs market. These countries should buy drugs only from countries and companies that follow the international rules and regulations on drug production for both domestic use and export purposes, and not from the cheapest unregulated manufacturers. Drugs should also be sold at highly subsidised prices to health facilities, making them affordable to local populations, and stored and transported appropriately to avoid damage.

To get these results, support from international health agencies is urgently needed to reinforce national drug supply systems or programmes. With affordable drugs in all health facilities, both rich and poor people

in developing countries will have access to the same standard of drugs, and the fight against retailers in the street and other informal companies will have more chance of success.

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I declare that I have no conflicts of interest.

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Beyond cholera—the Zimbabwe health crisis

All I wanted to do was to wash my hands. Hunched over the sink in quiet solace after a hard day in the cholera ward, I was at peace. And then it happened, “Eric, there’s a baby I want you to see.”

The Zimbabwe cholera outbreak of 2008–09 surpassed the WHO worst-case scenario. In the end, WHO reported 100 000 cases and 4200 fatalities. These values were likely underestimates, because during the crisis reporting clinics were largely on strike, communication was severed by stolen telephone lines, and deaths in the bush devalue as fast as the currency.

Community-based verbal autopsies might be the only way to know the true numbers someday.

In addition to the size, the length of the outbreak was unprecedented. Ironically, one hypothesis is that years of public health success meant *Vibrio cholerae*, the cause of cholera, was not sufficiently present to provide natural vaccination. A susceptible population paired with the ubiquitous failure of the Mugabe government to provide clean water made Zimbabwe a modern-day cholera frenzy.

Our team’s assistance was requested by a rural hospital because we had coauthored an ebook, *COTS Program*, on the management of cholera outbreaks. We had lived in the ugliness of cholera in Bangladesh. When we arrived in Zimbabwe, we felt confident. But this outbreak proved different.

The mother sat in the corner with the baby swaddled in her arms. Her posture was frank, her impatience mute.

Her 2-week-old was a sick baby. Chestwall not rising. After a pause, a gasped breath. Faint irregular pulse. Floppy limbs. Feverish.

The differential diagnosis was broad. This child definitely did not have cholera. Cholera is the painless death. You sit on the toilet and observe in wonderment as the fluids of your body exit with haste, without effort, distress, or fever.

Cholera treatment is simple: oral rehydration solution (litre upon litre). Antibiotics only shorten the course of the disease. Untreated, cholera rapidly kills 20% of its victims; if treated, fewer than 1% die.

Topping the differential was group B streptococcus. However, diagnosis was secondary, and resuscitation was now primary. I inserted a needle into her arm—with a passive flash of blood, I pushed deeper to get the real thing. No blood. Weak pulse.

I ran down to the house to get the medical director. I told her we had a young tyke with a limited desire to breathe. She sighed and flipped a page of her novel. Gazing over her spectacles she smiled and calmly said, “fluids... cefotaxime if it’s in stock, ampicillin otherwise”. She had raised her book before I had turned. It would take me days to appreciate that I had just had my first lesson in triage.

The Zimbabwean dollar is dead—it doesn’t matter how often you subtract zeroes off the currency. If you want a radiograph, the cost is six chickens. If you want cefotaxime, pray that a donor donates it.

For more on COTS Program see
<http://www.cotsprogram.org>



A cholera ward in Zimbabwe

“Where is the director?” my colleague asked as she jabbed a 14-gauge needle into the infant’s shin for an intraosseous line. “She’s not coming”, I responded.

Still no flash of blood. I began fishing for access in the femoral vessels. A button of blood formed at the site.

33% of people in this community are infected with HIV—15% nationally. At least one in 20 harbour tuberculosis. Zimbabwe also has what the local colloquialism calls TB2, which means the patient has HIV and TB too.

I watched the blood smear onto my ungloved hands. The child could have HIV.

Recurrent closures of clinics and maternity wards have made mother to infant HIV transmission hard to prevent. Together these factors make the perfect recipe for generating a nidus of resistant pathogens.

“Eric stop...Eric!”

No pulse. No gasp. No life.

Heads low. Angst high. The director laid her book softly down as we shuffled in. She removed her glasses and tucked them next to the book.

She shook her head slowly, “the child was dead on arrival. There was nothing you could do.”

All I can do is this, share the Zimbabwean story, unmask the truth. Repeat that the government must take sincere, open, and informed action. Until then, HIV and tuberculosis will continue to gain resistance, the millions of dollars invested in Zimbabwean HIV and tuberculosis prevention will be wasted, and the cadre of infectious ills in Zimbabwe will remain out of control.

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